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Epidemics and Public Health in Late Colonial Somaliland

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The literature on empire and disease is extensive,¹ but the issue has been so far ignored in Somali studies.² In an earlier paper,³ I discussed the history of disease and empire in Somaliland during the early colonial period (1900–1939). This paper extends the argument for the late colonial period (1939–1960). Various diseases such as smallpox, measles, relapsing fever, tuberculosis, influenza, and venereal diseases swept through Somaliland in the late colonial period. The social context for the spread of the diseases was, first, the economic devastation caused by the various droughts in 1943, 1947–49, 1950, 1955, 1956, and 1959. Second, the migration of the drought victims across the frontiers, which often introduced the vector of the diseases into virgin territories. And third, the growth of the population of the towns as more and more rural paupers settled in the towns in search of better and more secure life. The paper elaborates how the migration of patterns of paupers, and growth of the population of the towns led on the one hand to an increase in the incidence of epidemic (in the rural areas) and endemic (in the towns) diseases. The paper is divided into three sections. The first section deals with epidemic diseases, the second with endemic diseases, and the final section with public health policies.

Epidemics

The 1943 drought created “famine conditions” throughout Somaliland particularly in the western districts (Hargysa and Borama-Zeila). During the drought at least 60 percent of the sheep, goats, and cattle stock, and 10 percent of the camel stock including a “large proportion of calves”⁴ perished. In response to the crisis, the administration opened relief camps for “starving people” “on a small scale in Burao and Berbera,”⁵ and on an “an extensive scale”⁶

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in Borama and Zeila. Grain, for instance, “was issued to over 20,000 people in one day in Borama; while special arrangements were made in the hospitals at Borama and Zeilah to give milk and vitamin oils to children who were suffering from the effects of malnutrition and incipient starvation.”⁷ Victims of the drought that migrated from Ethiopia introduced a smallpox epidemic into the western region. The “disease (smallpox) is endemic in Ethiopia,” the 1943 administrative report stated, and is introduced into the country through the “nomadic population of British Somaliland.”⁸ Ethiopia’s metropolitan centres had always been the source of smallpox epidemics for Somaliland. The disease becomes endemic only in large cosmopolitan centers from where it makes forays into areas where the people have no immunity.⁹ The epidemic broke out in January and continued to affect the victims of the drought in the camps until December. The “recorded cases” were as follows: 74 cases in January; 80 cases in February; 120 cases in March; 235 cases in April; 240 cases in May; 105 in June; 36 cases in July; 60 cases in August; 24 cases in October; 121 cases in November; and 61 cases in December. The highest rate of infection took place in April and May “chiefly at Borama and the Abyssinian frontier.”¹⁰ In November and December, in contrast, the highest “recorded cases” were confined mainly to Hargeysa. Probably there were many unrecorded cases in the interior.¹¹ As a rule, figures quoted by medical reports reflected only the number of people treated in hospitals. As the reports repeatedly asserted, hospital figures were necessarily misleading. Since “hospital figures deal more with the urban than rural population (they) give a very false picture of mortality (and morbidity) among the general population.”¹²

Two other smallpox epidemics broke out in the country in 1953–54 and 1959. The 1953–1954 epidemic was introduced from Ethiopia towards the end of 1953—a period in which the border area was unsettled, because the Ethiopian government was attempting to assert sovereignty over the Ogaden and the Haud. As early as 1949, the British cabinet decided—once the whole idea of “Greater Somalia” under British rule was defeated by the other great powers, particularly the United States and the Soviet Union—to hand over the disputed territories (Haud and Ogaden) to Ethiopia. The agreement between the two nations was reached in 1953, but formally announced in 1954. Meanwhile, the Ethiopian government intensified its assertions of suzerainty over the Haud. The political

instability in the Haud forced people to migrate to Somaliland, and so infected cases introduced the disease into the western region, which then spread eastwards. As one report put it, “the general tendency was for the disease, which continued to be a very mild form of Alastrim, to spread from the West and centre of the country to the East and South and from towns to rural areas.”¹³ The epidemic reached its peak in 13 February 1954, when 88 cases were reported. Thereafter it began to decline. The last case reported was in 18 September 1954. Overall, 240 cases were treated in 1953 and 818 cases in 1954. Only 487 were admitted to hospitals. There was only one reported death: the patient suffered from a “severe and neglected cellulitis of (the) arm which was thought to have followed vaccination so that on the face of it an attack of Alastrim seems to have been the safer method of acquiring immunity.”¹⁴

The 1959 smallpox epidemic was also mild. The epidemic began in Ethiopia in August 1959, followed the railroad to Djibouti in September, and in “November 1959, it invaded Somaliland.”¹⁵ The outbreak was detected in late November, but was confined to the Borama district, and was “clearly . . . initiated by the entry of infected persons from the adjoining area of Ethiopia” and Djibouti.¹⁶ Overall, 94 cases were diagnosed in Borama and Hargeysa districts, of which seven died.¹⁷ There were probably many other cases in the interior. The speedy dissemination of the contagion from Ethiopia to Djibouti to Somaliland owed a great deal to improvements in transportation,¹⁸ which facilitated the movement of peoples and contagion. It was also facilitated by “fairly severe drought” in the country in 1959, particularly in the frontier region with Ethiopia, from November 1958 to April 1959, in which “large number of stock were lost,” and in which pastoralists experienced “harsh conditions.”¹⁹ The drought forced the people to migrate across the frontiers and carry the disease with them. The impact of the epidemic, however, was limited. First, people acquired immunity to the disease because of the prevalence of the disease in the country since the early colonial period.²⁰ A 1946 report, for instance, noted the fact that “[e]xtensive epidemics of smallpox occur[ed] from time to time.” The report added that impact of the disease was limited by the acquisition of immunity. In 1946, according to the report, 40 percent of the population had immunity to the disease as a result of “a previous attack of smallpox or vaccination.”²¹ Second, public health policies mitigated the impact of the epidemic: on the one

hand infected cases were isolated in special hospitals and camps, and on the other water and food was carried to the people in the interior which limited mass migration.²² In Somali traditions, the drought is known as “gaadhi-ghaadhi saar” (truck placed upon a truck), which refers to the water containers carried by trucks into the interior.

Besides smallpox, malaria epidemics posed the most persistent health hazard to the population. Geographically, malaria epidemics were most common in the southern grazing area—that is, the South and Southwest—along the Ethiopian border. The other geographical zones were affected unevenly. The coastal plain, “Guban” (burned land), for instance, was too dry to be a source of malaria epidemics. The mountain escarpment, in contrast, had from the 1930s onwards, according to the director of the East African Malaria Unit in 1949, D. Bagster Wilson, a “moderately high level of endemic malaria . . . associated with the small water collections along the stream beds.”²³ Endemic malaria in the mountain region, according to Wilson, was “sufficiently high for a certain amount of immunity to be acquired.”²⁴ It was in the southern grazing area, however, that “epidemic occurrence of malaria”²⁵ was most persistent. The “annual epidemic (in southern region), which is usual in one part or another or even the whole of these grazing areas, is essentially attributable to breeding in the rain pans, large or small, that form in hollows to which drainage from the surrounding ground runs.”²⁶ After the rains there is usually an interval of about a month before mosquitoes become noticeable, then “epidemic malaria may become apparent.” But he was unsure about the “genesis of epidemics in the wide area to the south, in which they are likely to occur.” This issue, he admitted, “is more obscure.”²⁷ After all, the mountain escarpment received more rain, and had more water than the Haud. In addition, since epidemics were frequent in the region, why did the people not acquire immunity to it?²⁸ The process of transmission of malaria infection in the country also puzzled Glasgow and MacInnes—two medical practitioners in Somaliland. They concluded that perhaps a key factor in the spread of the regular epidemics in the country were the “exceptional aggregations of a nomadic population around residual water.”²⁹

Frederick Dunn recently pointed out that malaria transmission “depends upon the complex interaction of parasites; vector mosquitoes; physical, socioeconomic, and environmental factors; and human biology, demography, and behavior.”³⁰

Rainfall is not the only determining factor in malaria epidemics. Equally important were the “number of persons harbouring malarial parasites,”³¹ and the introduction of infection into new areas by migrants. Since immunity to malaria is species-specific,³² the introduction of new species often leads to epidemics. Two examples would be used to elaborate the argument: the 1949 and 1951 epidemics. In 1949, for instance, an epidemic swept the country, which followed the 1947–1949 drought. The 1947 drought “continued until the end of March (1949)” and “as a result livestock, especially sheep and goats, suffered in all districts and crop planting was retarded.”³³ Shortly after the beginning of the rains, a malaria epidemic raged throughout the southern region. In Duruksi and Yooboros “epidemic conditions were just rising,” in Morodi Qadr the “epidemic was in full swing,” in El-Dab the “epidemic was waning,” and in the “whole area between Ainabo and the southern border a severe epidemic was in progress.”³⁴

The 1951 malaria epidemic also followed on the heels of the 1950 drought—which is well known in Somali oral traditions as “Seega Case” (Season of Red Winds). The severe conditions created by the drought—“large numbers of stock died, leaving those dependent upon them for sustenance, destitute and starving”³⁵—were further aggravated by a locust invasion. By October 1950, a relief camp for drought victims was opened at Erigavo, which fed 150 destitute persons, and by the end of October, two other camps were opened for destitute persons at Garadag, and El-Afweyn. The total number of inmates of the camps (all three) by the end of October was 1,700. The number of people seeking help steadily grew. By the end of the month, the medical department and the government realized that a “major crisis was imminent and that a co-ordinated measures for famine relief were necessary.”³⁶ The medical department followed a simple policy: only women, children, and the infirm were admitted to the camps. The men were given employment in either famine relief work, or on road building. By early 1951, other camps were opened at Badhan, Burao, and Berbera, and the number of inmates reached 9,000. By the middle of the year, 10,000 people were cared for in the camps. The drought affected most severely infants and the young who suffered the highest mortality rate. The causes of death were “extreme malnutrition with concomitant diarrhoea”³⁷ and terminal gastro-enteritis “associated with the general malnutrition.”³⁸ The average death rate between February and April 1951, in the Erigavo and Badhan camps, for instance, was

10–12 per week per thousand inmates. In other camps the rate of death was lower. In the El-Afweyn camp the death among children was half the rate of the Erigavo and Badhan camps.³⁹ About 1,000 people died in the camps, or 10 percent, mostly children.⁴⁰ Towards the end of March, the summer rains brought the land back to life, and as a result the people began to leave the camps in large numbers. By the end of the year there were only 2,000 people in all the camps.⁴¹

The 1951 malaria epidemic followed on the heels of the 1950 drought. The summer rains began in mid-March 1951, and at the end of May, a general increase in the incidence of malaria was reported, and in July, a malaria epidemic reached peak level. It declined slowly in August, and came to an end at the beginning of September. Overall, 2,329 cases were admitted to hospital. Medical officers estimated a mortality rate of one or two percent of the total population.⁴² The high rate of death “was intensified by the generally poor state of nutrition of the people following the famine.”⁴³ Droughts always preceded malaria epidemic. As drought victims migrated, they introduced new strains of malaria infections, and at times new species of malaria, into towns and refugee camps. In 1954, for instance, the medical report excitedly noted “the discovery of a species of mosquito not previously recorded in Somaliland.”⁴⁴ The specimen was discovered at Zeila and at Abdulkadir following the rains in September/October 1954. The species was identified as *A. pharoensis*. A sample was sent to the entomologist of the East Africa Malaria Research Unit who confirmed the identification.⁴⁵ The introduction of new species often led to the spread of “seasonal epidemics,”⁴⁶ particularly in towns along the border such as Borama, which had “an annual epidemic of greater or less extent.”⁴⁷

The 1956–1957 malaria epidemic also followed the 1956 drought, which lasted from January to October. One month after the rains began in early October, an epidemic broke out throughout the country. In the Erigavo district, where the epidemic was most severe, 1,402 cases were reported. The medical department controlled the disease through a vigorous spraying campaign in, for instance, El-Afweyn, Garadag, Huberra, Badhan, and many other villages in the Erigavo district, as well as other districts.⁴⁸ In 1957, another malaria epidemic swept the country, following the 1957 drought. The “greatest number of malaria (cases) occurred in the South east of the Protectorate.”⁴⁹ Despite the high incidence of malaria throughout the country, neither the morbidity nor the mortality rates

were as high as 1951—”a season of good rains following a famine.”⁵⁰ The 1957 report maintained that the difference was that the control measures against the vector of the disease from 1951 to 1957, resulted in the “reduction of adult anophelines that their transport to, and re-establishment in, the casual breeding places in the southern grazing areas is hampered and delayed.”⁵¹ In reality, the difference lay in the severity of the droughts in 1950 and 1956–57, and the migration patterns of drought victims. The 1956–57 drought was not as severe as the 1950–51 drought, and so the people neither migrated in massive numbers, nor severely weakened by hunger. Overall, 1,836 cases were treated in the hospitals. Yet another mild epidemic broke out in the country in early 1958, in which the morbidity cases reported were 1,326.⁵² In general, droughts and migration across borders were a central factor in malaria epidemics.⁵³ And the severity of the epidemic almost always depended on the severity of the drought, and the number of migrants.

The migration patterns of the population also played a key role in the spread of influenza, pneumonia, measles, and meningitis. Meningitis is a “highly seasonal disease” that spreads during cool dry seasons, when overcrowding takes place, and people huddle together in small areas.⁵⁴ It comes to an end once the rains fall. During the 1947–48 meningitis epidemic, for instance, a “large proportion of deaths was in the Midgan area of Burao township,”⁵⁵ an overcrowded sector. One hundred eighteen cases were admitted to hospitals “with a total case mortality of 10 per cent.”⁵⁶ Measles, however, was more prevalent than meningitis and broke out in epidemic form in 1954, 1955, 1956, 1957 and 1958. Measles, like meningitis, had a “winter-spring seasonality,” and had always been the “indirect effect of climate on socioeconomic conditions and population movements.”⁵⁷ The 1954 medical report stated that “Measles is normally sporadic in incidence in this country with epidemics at intervals of two to three years.”⁵⁸ The 1954 epidemic “was quite considerable,”⁵⁹ as it was “country-wide and affected . . . young adults as well as children.”⁶⁰ Among infants, broncho-pneumonia complicated measles infection. Overall, 712 cases were treated. In this epidemic “as in other (epidemic) diseases, the cases seen at hospitals represent only a fraction of the incidence and indeed it is probable that, at least so far as infants and young children were concerned, only the more seriously ill cases, with complications, were brought to hospital.”⁶¹

Another measles epidemic broke out in the country from January to April 1955. The epidemic affected both the Las Anod and Erigavo districts in the dry season, a vulnerable period for pastoralists: it is time “when families come to the permanent water for the small stock. It is also when they live in very close proximity and isolation is impossible to enforce.”⁶² The epidemic spread to Hargeysa in May and from there to Berbera in October. The infection was “probably the result of a fair number of families moving from Hargeysa to the coast in September-October, a normal movement of population, and carrying the infection with them.”⁶³ About 845 infected cases were treated in the Hargeysa hospital.⁶⁴ The disease continued to appear throughout the country in sporadic form and was a “frequent cause of broncho-pneumonia.”⁶⁵ But the death rate was very low indeed. The 1956 epidemic, for instance, was a “small epidemic” that spread throughout the country, but which caused only three reported deaths (complicated by pneumonia). Its victims were “the children in the Famine Camp in May” but not “to a great proportion.”⁶⁶ The total cases treated in the hospitals were 875.⁶⁷ In 1957, the incidence of the disease declined slightly. Only 108 cases were reported. In 1958, it re-emerged in epidemic form in Borama where 720 cases were treated in the hospital.⁶⁸ It was a “minor epidemic” that raged in the spring in Borama and Hargeysa and towards the end of the year in Burao. It spread as “a result of the overcrowding that results from the seasonal move to the towns.”⁶⁹ It essentially consisted of “two minor epidemics.” The first one took place in the spring in Borama, when people moved from the Guban to the Borama area. In the spring the Guban is too hot, and people migrate southwards. The second one took place in the last two months of the year in Burao and Hargeysa, when people moved back from the Haud and the southern grazing areas as a result of water shortages. The 1958 medical department report maintained that “it is probable that the disease is smouldering in the interior,” follows people’s migratory routes, and reaches epidemic level in overcrowded conditions.⁷⁰

Pneumonia, unlike measles, was not contagious, but like measles it was “an annually occurring epidemic disease.”⁷¹ It begins to spread in December and reaches peak level in January and February. The “various contributory causes” to the disease are temperature⁷² as well as diet. The winter months (December to February) are “intensely cold,” but the pastoralists of the interior often use

“thin cotton garment”⁷³—particularly the very poor—and so body temperature falls drastically. The winter months, in addition, “tend to be hungry ones when a state of semi-starvation may be widespread with a consequent lowering of the individual resistance to disease.”⁷⁴ Water in these months “is also short so that stock have to be driven long distances to permanent wells to be watered and during this process the herdsmen are drenched. Inadequately clothed, exhausted, hungry, cold and wet it is hardly surprising that they succumb to pneumonia.”⁷⁵ The disease, then, is of “multifactorial nature”⁷⁶: temperature, food consumption, nature of work, and clothing, all played a role in its incidence. For instance, during the 1950 drought, 95 cases of death of lobar-pneumonia and 81 cases of death of broncho-pneumonia were reported in the camps.⁷⁷ The hunger and the cold—which were most severe in winter—facilitated the spread of the disease. Meanwhile as the disease was ravaging the hungry, the health of the people was further weakened by a “pandemic Influenza which swept the Camps in March, 1951,” and which caused “considerable mortality amongst the very young and the very old.”⁷⁸

Unlike pneumonia, influenza is contagious, but like pneumonia, it has multiple sources of infection, and in particular, three different causative myxoviruses—A, B, and C. The A and B “viruses are associated with sporadic epidemics among children and young adults, and do not cause pandemics,” so that the mortality rate is usually low—about 1 percent.⁷⁹ Since it is contagious and is spread by airborne droplets from person to person, it is most prevalent in overcrowded areas, though it does not require large populations to maintain itself.⁸⁰ In Somaliland, it usually began in the coastal towns, moved to the relief camps and then spread to the interior towns. In 1951, it “caused very little mortality” even though it probably facilitated the mortality in people suffering from pneumonia.⁸¹ The disease continued to haunt the people albeit in a mild form particularly during droughts in 1956, 1957, 1958, and 1959.

In late 1955 three problems confronted the rural folk: drought conditions, a locust invasion that devastated pastures and crops, and an “outbreak of disease among the stock [which] caused very heavy losses in the herds.”⁸² These events “resulted in famine conditions in March, 1956,”⁸³ particularly in the western region, where the rural folk “had little or no money to purchase food as their normal sources of income from hides and skins were much reduced by stock

losses and a fall in the price of skins.”⁸⁴ Grazing was also poor in the eastern districts such Burao and Las Anod where the pastoralists were “unable to live off their stock or obtain good prices for their animals.”⁸⁵ The government did not open any relief camps in the eastern districts since the level of hunger was not extreme, but “introduced special works” that employed “a great deal of extra labour” that gave the pastoralists the income “to buy food and avoid starvation.”⁸⁶ In the western district, the medical department opened a relief camp in March at Abdulkader, a small village between Zeila and Borama. Two hundred eighty women and children were admitted in the camp who were “in the early stages of starvation,”⁸⁷ though no cases of oedema or extreme manifestation of starvation were seen. The continuous loss of stock and the increase in the price of food led to the rise in the population of the camp. By June 1956, there were 400–500 poor women and their children. The men were provided with employment. By August, there were 700–750 people in the camp.⁸⁸ Even though rains were good in late 1956, the camp remained open throughout the year. Indeed it was closed only March 1957. Meanwhile the “famine conditions rendered the population more liable to infectious diseases”⁸⁹ such as influenza. The 1957 “Asian Influenza pandemic invaded the Protectorate in June.”⁹⁰ It spread from Aden to the coastal towns—Berbera, Heis, and Mait, and then “spread to all stations but retained its mild character,” and as a result, most of the infected cases were “treated at home.”⁹¹ By November, the epidemic died out.⁹² Overall, 2,459 cases were treated in the hospitals.⁹³ It resurfaced briefly towards the end of 1957 and “continued into the early part of 1958 but then died out.”⁹⁴ Again it resurfaced in mid-1958 in the towns, where a total of 691 cases were reported.⁹⁵ It went into remission, and then re-emerged as a “small epidemic” in the last few weeks of 1958 and up to January and February 1959, when 2,227 cases were reported. The context of its resurfacing in late 1958 and early 1959 was the drought of 1959, which forced many people to congregate in overcrowded areas.⁹⁶

Endemic Diseases

Meanwhile, diseases such as tuberculosis, gonorrhoea, and syphilis became endemic in the towns. The urban history of Somaliland is still undeveloped: there are few studies on post-colonial⁹⁷ and pre-colonial⁹⁸ towns, but no studies

on colonial towns. There is no space to discuss the issue in detail here. Suffice it to say that all the modern interior towns (not the coastal towns) of Somaliland were colonial towns. (Coastal towns such as Berbera, Xiis, Bulhar, and Zeila had ancient origins.) The modern interior towns were of recent origin, and their population was made up of recent migrants from the interior.⁹⁹ In 1921, for instance, the built environment of Hargeysa consisted of one stone building, a small number of huts, and few administrative buildings.¹⁰⁰ By 1945, Hargeysa had 255 stone buildings, and a few hundred huts,¹⁰¹ and by 1956, the town had over 7,020 registered stone buildings and a substantial number of huts.¹⁰² As the built environment of the town expanded so did its population. In 1921, its population consisted of a few hundred people, by 1946 its population reached over 40,000, and continued to expand.¹⁰³ By 1959, “perhaps 10 per cent of the population in recent years have become fairly permanent town-dwellers, developing many of the varied characteristics of townsmen.”¹⁰⁴

Like all colonial cities, the built environment of modern towns in Somaliland was hierarchical and uneven. Fanon famously characterised the colonial town as a place of “reciprocal exclusivity”¹⁰⁵ that consists of “two zones”: European space—a “brightly lit town,” and “native” space—a hungry town, “a place of ill fame.” “Native” spaces in colonial towns were not, however, homogenous. Rather, they were broken up into two different spaces, even if they were not reciprocally exclusive: the sector of the well-off Somalis, and the space of the poor migrants. The 1949 colonial report distinguished between the sector of the “modern permanent houses,” which are the “property of the wealthier Somalis,”¹⁰⁶ and the sector of the “lower class” whose “housing standards are . . . universally poor.”¹⁰⁷ The “lower class” lived in movable huts—“Aqal”—constructed of “wooden struts over which are thrown mats made locally from grasses and fibres of bark.”¹⁰⁸ When the “Aqal” is used “under nomadic conditions (it is) comparatively clean and healthy, but when used as permanent and static dwellings on the outskirts of towns, slum conditions are quickly created.”¹⁰⁹ In 1946, 32,000 of the 40,000 inhabitants of Hargeysa lived in the slums. The three spaces in the colonial towns were distinguished by architecture. The European space was marked by the bungalow¹¹⁰; the space of the “wealthier Somalis” by modern permanent stone buildings; and the space of the lower class by the “Aqal.”

In 1945, a committee of inquiry investigated the causes of poverty in the countryside and the towns. The “main recurrent cause of poverty in the interior is drought.” After a drought rural paupers, particularly the young, migrate to the towns in search of employment and better life.¹¹¹ The paupers were attracted to the towns because of the increase in employment opportunities created by government and private investment. In Berbera, “there has clearly been some increase” of the juvenile population “owing to additional chances of employment and pilfering.” And in Hargeysa, a “very considerable floating population” has been attracted to the town because “the largest circulation of money in the country may be found in Hargeysa, and the greatest employment opportunity.”¹¹² Although the economy of the main towns expanded during the war and the post-war period the available opportunities were not large enough to satisfy the hunger for employment of the migrants. As a result myriad social and medical problems emerged: “young men drift into crime and vagabondage and young women into prostitution.”¹¹³ In addition, since they could not afford to rent permanent stone houses, they congregated in the slums, which quickly created “insanitary conditions.”¹¹⁴ “Urbanised communities,” particularly low income communities, as one report put it, were “subject to bad housing conditions, constant under-nourishment, poor sanitation and the risk of communicable diseases [such as] venereal diseases, tuberculosis and other respiratory complaints, tropical ulcer, conjunctivitis.”¹¹⁵ The 1951 medical report stated, for instance, that tuberculosis is becoming increasingly “endemic in the towns of Somaliland” but still “rare in the interior.” Because they had no immunity to the disease, new migrants were “exposed to special risk.”¹¹⁶

The rise in the incidence of tuberculosis, according to T. F. Anderson’s report, “*The Medical History of Somaliland, 1939–1944*,” was caused by “grossly overcrowded” living quarters in the slums and malnutrition.¹¹⁷ The 1956 report pointed to the “ample evidence that poor ventilation, bad lighting, and overcrowding in unhygienic huts contribute[d] to the spread of the respiratory type of tuberculosis.” “In theory,” the report added, “it should be easy to check. In practice, however, economics . . . present[s] a formidable barrier to desirable changes.”¹¹⁸ The economic problems of the urban poor in, for instance, the towns of the Makhir coast—Heis, and Mait—were manifested through “oedema, with transient cardiac murmurs in some cases. It was not a

true Beri-Beri but appeared to be definitely a deficiency disease. It was rather prevalent in children than adults.”¹¹⁹ A “similar outbreak occurred in Berbera in the period May/July among the poorer section of the population of the town who were existing on very small quantities of parboiled rice with few extras.”¹²⁰ The syndrome was also prevalent among the poor classes of Hargeysa as well as other towns. “The condition,” the report stated, “appears to be nutritional in origin.”¹²¹ The nutritional deficiency of the urban poor was further exacerbated by poor housing, which created the condition for the spread of infectious respiratory diseases. The 1951 report stated that the “vast majority of townspeople live in “gurgis,” round huts covered with matting.”¹²² There was housing available, but the poor could not “afford the rent of Sh. 30.00 per month or more, normally paid for the most inadequate stone or brick living place.”¹²³ Income has always been the key determinant in the incidence of the disease: “when social conditions deteriorate,” William Johnson argued, “the incidence of tuberculosis rises quickly.”¹²⁴

In 1954, the medical department undertook with the cooperation of the World Health Organisation an extensive survey of the prevalence of tuberculosis in the urban areas.¹²⁵ The survey team visited only urban centres: Burao, Borama, Amud, Erigavo, Gabileh, Mait, Hargeysa, and Berbera, but systematically surveyed only Burao and Berbera. In Burao, for instance, each street chosen for examination was marked, and every household in each street chosen for examination was given a number and painted with a sign at its entrance. Every effort was made to include both sectors of the town: the hut section, and the permanent stone-house section. During the medical examination, women were brought from the market, men from work, and children from school. In each household, the full name, age, sex, status of each individual in the family, and the total number of individuals in each household was registered. Each individual whether young or old, was made to cough as vigorously as possible and then spit into a plastic box, which was then placed in a jar, and transported to the District Hospital where the sputum was examined with a microscope. The people’s cooperation with the survey team was more than satisfactory. According to the team, 95 percent of the people selected for the survey in Berbera, and 91 percent of the people selected for the survey in Burao, attended the examination. The survey team concluded that in both

towns the rate of infection among all age groups was very high, as can be seen in the table below.

Table 1. Percentage of All Age Groups that Tested Positive in Burao

Age-group	percent that tested positive for T.B.
0–4 years	19.3
5–9 years	44.3
10–14 years	73.4
15–19 years	81.6
20 years and over	86.4

Source: World Health Organization. Tuberculosis Research Office. *Tuberculosis Survey of the Somalilands* (Copenhagen, 1956). Tabulated from Figure 4.3.

The methodology of the survey team was deeply flawed in several respects, however. First, the survey team did not re-test the people whose sputum showed acid-fast bacilli with x-ray. Rather, they were satisfied with the microscopic test of the sputum. Second, the sputum was examined after three weeks, rather than one week. After one week, many other micro-organisms grow in the sputum other than tubercular bacilli. Third, the sputum was not appropriately transported nor kept in a cool environment. The jars were transported from the survey areas to the hospital in cars without refrigerators. The survey team pointed out all of these problems, but lightly dismissed them. The team insisted that if the conditions were more favourable, they would have detected “an even higher number of positive sputa.”¹²⁶ Yet the morbidity rate reported in the hospitals were rather meagre: a total of 740 cases in 1955, 739 cases in 1956, 657 cases in 1957, and 808 cases in 1958.¹²⁷ What worried the administration, nonetheless, was the possibility of the disease reaching epidemic levels in the overcrowded and insanitary conditions in the towns, and then spreading to the interior, since there was constant traffic between the towns and the rural areas.

Meanwhile, the incidence of sexually transmitted diseases, in particular gonorrhoea and syphilis, increased particularly during the war. Three factors were

important in the incidence of the disease. First, the growth of the population of the towns; second, the increase in the number of prostitutes in the towns; and third, the increase in the number of soldiers during the war: major wars, as Kenneth Kiple put it, always increased the incidence of syphilis.¹²⁸ One report, for instance, stated that “women are now infected [with VD] in every town where troops are stationed.”¹²⁹ By 1946, the number of venereal diseases treated were 5,308 of which 2,929 were syphilis and 1,886 gonorrhoea. Chancroid cases were uncommon, which indicates the recent spread of the disease. The “immediate cause of the rise of V.D. in recent years has been the great increase in prostitution. V.D. is mainly a disease of the towns where prostitutes and vagabond youths congregate.”¹³⁰ For T. F. Anderson the “effects of the war on public health”¹³¹ had been profound. The “marked increase in prostitution and venereal diseases” was “perhaps inevitable when it is considered that large number of alien and native troops employed by the Italians and ourselves have been quartered in the country for practically the whole duration of the war.” Foreign troops introduced venereal diseases among prostitutes, which then spread further among the young migrants as well as among the older male population. It is, as he put it, “one of the many social evils which has been occasioned by the war, and which will have a profound effect on the Somalis for many years to come.”¹³² By 1948 venereal diseases were “becoming a serious menace to the health of the people.”¹³³ (Table 2) Venereal diseases “have increased alarmingly during the last decade,” according to John Hunt, “especially with the opening up of the Ethiopian frontier, increased travel by motor lorry, and the rapid movement of troops during the war.”¹³⁴

From 1950 to 1959, the rate of syphilis infection declined, while the rate of gonorrhoea increased. Although the 1951 medical report stated that “No significant conclusions can however be drawn from these trends,”¹³⁵ an inference could be made about the cause of these trends. The departure of foreign troops was probably the main reason for the decline of syphilis. But even the obvious decline in figures (Table 2) must be tempered by the fact that a large number of people did “not come in for examination and treatment.” Unlike tuberculosis, which the people sought assistance for quickly, the control of venereal diseases faced two problems: “ignorance of the seriousness of the disease (gonorrhoea) and a reluctance and dislike for a proper examination.”¹³⁶

Females particularly avoided “proper examination” since there were no female doctors in the territory, and female nurses were too few. Hence there was probably “many female cases who never attend for treatment and therefore continue to spread the disease.”¹³⁷

Table 2. Venereal Diseases, 1956–1959

	1956	1957	1958	1959
Syphilis	777	473	416	609
Gonorrhoea	4,132	5,297	3,750	3,610
Chancroid	62	88	115	181

Source: PRO, C.O.830/10, Medical Department Annual Report, 1959; Medical Department Annual Report, 1958.

The complex interaction between socio-economic, demographic, environmental, and human behaviour also played a key role in the gradual increase in the incidence of other diseases such as relapsing fever from 1946 to 1950. Relapsing fever is a “true famine disease” because “mortality varies inversely with living conditions.”¹³⁸ It achieves high level of endemicity in areas where the standards of housing, hygiene, and nutrition are low. In that respect, it is the “most epidemic of the epidemic diseases.”¹³⁹ The disease had an “endemic focus in Ethiopia, making excursions into neighbouring Sudan”¹⁴⁰ and Somaliland. In Somaliland, it was first diagnosed in 1913, and reached epidemic level in the mid-1930s in the towns.¹⁴¹ It declined in 1938–39. The vector of the disease was re-introduced into the country during the war, due to increased traffic between Somaliland and Ethiopia. The disease always followed the highway of commerce, refugees, migrants, and armies from Ethiopia into Somaliland. In the 1940s, it reached epidemic level in Hargeysa, Burao, and Borama. In general, the disease did not affect the rural folk: it had always been a “serious disease” only “at larger centres of population,”¹⁴² and specifically in livestock markets, slums, and mosques where poor travelers and migrants slept the night.¹⁴³

Table 3. Incidence of Relapsing Fever

Year	Number of Cases in Burao	Number of Cases in the whole country
1946	488	625
1947	313	445
1948	179	250
1949	85	216
1950	33	265
1951	4	54
1952	3	15
1953	0	0

Source: W. C. D. Lovett, "Eradication of Tick-Borne Relapsing Fever in the Somaliland Protectorate By a Tick Destruction Programme," *Transaction of the Royal Society of Tropical Medicine and Hygiene*, vol. 50, no. 2 (1956), p.161.

Despite the frequent occurrence of various endemic and epidemic diseases, their impact on the population was less severe than in the early colonial period. The demographic history of Somaliland has not yet been given scholarly attention. Generally, demographic changes in Somaliland during the colonial period followed a pattern familiar to historians of the continent. The population declined in the early colonial period, but "rapidly grew after World War Two."¹⁴⁴ The evidence for Somaliland as for the continent is at best sketchy because vital statistics on birth, death, and migration, are not available. No census was successfully undertaken and completed in Somaliland, because of the "strong aversion of the Somalis to 'a numbering of the people'"¹⁴⁵ The rural folk particularly distrusted the "numbering of people" because they viewed it as the first step in the imposition of direct taxation. The raw materials of historical demography, then, are unavailable to the student of Somali history.¹⁴⁶ But the lack of vital statistics has not deterred historians of the continent from mapping the general trends in demographic changes. Often they have been forced to reconstruct historical "demography from scanty sources" keeping in mind by-the-by that all sources represent "the shadows of objects rather than

the objects themselves.”¹⁴⁷ All vital statistics, as Fetter states, are “reflection of the demographic process it purports to measure.”¹⁴⁸

The growth of the population of Somaliland in the post-war period could be gleaned from various sources. The 1945 report on pauperism, for instance, noted without presenting any figures, the “increase in population” as a result of the prevailing “peaceful state of affairs” in the country.¹⁴⁹ Before the war, according to the 1948 colonial report, “the population was estimated at about 350,000. More recently it had been put at 700,000.”¹⁵⁰ The 1951 colonial survey used the same figures.¹⁵¹ Only John Hunt made an attempt at a systematic survey of demographic trends. But even Hunt did not collect vital statistics. Rather he relied on tribal estimates. The use of tribal estimates as a form of population statistics was tried in the 1930s, but produced no usable results.¹⁵² Hunt was nonetheless able to produce numbers that were generally accepted by colonial administrators. The main focus of his research was the “dia-paying group”—the smallest tribal unit that shared the payment of blood money. “Somali society,” he argued, “is based on this group.”¹⁵³ He estimated the number of people that constituted each dia-paying group, and from that figure extrapolated the total number of the clan, and concluded that the population of the country doubled in the late colonial period. In 1944, he stated that the population grew from 350,000 to 720,000. In his final and official publication, however, he reduced the number of the dia-paying groups of the Esa and Gadabursi, by distinguishing between those who were “British protected,” and those who resided in Ethiopia. This reduced the population of the country in his estimate from 720,000 to 640,000.

Table 4. Population Estimates, 1951

	Number of Dia groups	Approximate population
Esa (British Protected)	57	55,000
Gadabursi	37	45,000
Habr Awal Saad Musa	50	100,000
Habr Awal Esa Musa	14	30,000
Arab	10	20,000
Eidagalla	19	40,000

Habr Yunis (Burao)	44	90,000
Habr Yunis (Other districts)	22	40,000
Habr Toljaala Mohd Abokor	31	60,000
Habr Toljaala Musa Abokor	19	40,000
Dolbahanta	48	100,000
Warsangeli	10	20,000
Total	361	640,000

Source: John Hunt, *A General Survey of the Somaliland Protectorate, 1944–1950* (London: Crown Agents for the Colonies, 1951), Table 18, p.122.

Hunt's figure was widely accepted and circulated in all colonial reports, and even in scholarly papers.¹⁵⁴ They were accepted not because the figures were scientific, but because there was a general and visible increase in the population of the country. Besides, they were the only figures available that used a methodology—albeit a weak one—to estimate the population. In addition, there were no massive wars, or pandemics, or epidemics that lasted for a long period and caused high levels of mortality. Even the 1943, 1953–1954 and 1959 smallpox epidemics were benign in comparison to smallpox epidemics in the early colonial period, because people acquired immunity to the disease by the late colonial period as a result of earlier infection or vaccination. In sum, the ending in the late colonial period of political instability, colonial pacification wars, the constant movement of armies and refugees across the frontiers, the people's acquisition of immunity to some strains of the diseases, and public health measures were the key factors that mitigated the demographic impact of the diseases.

Public Health

Public health policies were predominantly preventive in form, but did not ignore curative services. The policies addressed the rebuilding and expansion of medical institutions, public hygiene, control of the causes of endemic diseases, eradication of epidemic diseases, and rural health. The first priority of public health policies was the rebuilding of medical infrastructure. By 1943, the reconstruction of the old district hospitals and clinics was complete, and other new institutions were opened: a maternity and child welfare clinic at Burao and a

school for civil dressers, sanitary workers, and nurses was at Hargeysa.¹⁵⁵ By 1945, hygiene services were in operation in Berbera, Hargeysa, and Burao. Three years later, construction of new hospitals was begun in Las Anod, Burao, Berbera, Hargeysa. In 1949 new dispensaries were opened at Odweina, Darburuk, Ainabo, Sheikh; and new wards added to the Burao (120 beds), Borama (three new 22-bed wards), and Las Anod (45 beds) hospitals. A venereal disease wing for women was also added to the Ruth Fisher Clinic at Hargeysa in 1949, as well as to the Burao maternity and child welfare clinic. The department also established an ambulance service that picked up sick cases in the interior and brought them to the main hospitals. By 1951, all the main hospitals had experienced surgeons. In addition, a new hospital for T.B. patients was opened at Hargeysa hospital in 1954. And in 1958, tuberculosis wards were added to the Burao, Hargeysa, Berbera, Borama, and Gabileh hospitals. By then dispensaries were also opened at Mandera, Abdulkadir, Gabileh, Las Korey, Zeilah, Hiis, Mait, Hudin, Tugwajalleh, Adadleh. As a result of the expansion of services, medical expenditure—which was financed through Colonial Development and Welfare funds—expanded.

Table 5. Medical Expenditure 1943–1959

Year	Protectorate Expenditure (£)	Public Health Expenditure (£)	# Who Visited Hospitals
1943	—	13,754	—
1956	1,408,409	105,822	117,839
1957	1,715,683	114,878	112,458
1958	2,176,777	130,742	118,211
1959	2,390,757	143,481	141,461

Sources: PRO, W.O.32/9606, Minute, January 1944; PRO, C.O.830/5, Somaliland Protectorate Annual Medical and Sanitary Report, 1948; Colonial Office. *Colonial Office Annual Reports on the Somaliland Protectorate, 1956 and 1957*; Colonial Office. *Colonial Office Annual Reports on the Somaliland Protectorate, 1958 and 1959*.

The second issue the medical department addressed was public hygiene in the main towns—Berbera, Burao, and Hargeysa—because their built environment

and population were expanding. The medical department took an administrative approach in public hygiene. It divided the towns into sectors, and detailed town-sweepers and inspectors to each sector with responsibility for its cleanliness. Drums for refuse were placed at street corners, which households and business were expected to use, and which the sanitary staff emptied each day into a truck operated by town-sweepers. The sanitary staff also patrolled the town daily and inspected abattoirs, public latrines, rubbish disposal areas and incinerators, restaurants, teashops, bathhouses, and treated wells against malaria. The sanitary staff, in addition, imposed a “dry hour” every Saturday morning on all the towns, which was designed to prevent mosquito breeding. The staff required that each “household place all the dry water-containers lying on their side outside the house. The inspectors then enter the house to ensure that no standing water is concealed.”¹⁵⁶ The staff not only enforced public health policies but also “act[ed] as the eyes and ears of the Medical Officer or of the D.C. if an M.O. (medical officer) is not yet appointed.”¹⁵⁷ This multifaceted system was designed to “bring to light any unsanitary places and defects in the day’s work.”¹⁵⁸ The staff, furthermore, built public pit latrines as well as incinerators in the towns. Slaughterhouses were also brought under inspection in order to prevent the “danger of contaminated, disease-ridden meat.”¹⁵⁹ The staff feared that the slaughterhouses could become the center of epidemic disease since “flies swarm over these places settling first on the human faeces in the neighbourhood and then on the meat.”¹⁶⁰ Consequently slaughterhouses and meat markets were brought under the direct supervision of the public health staff. Indeed, in all the main towns, new markets and slaughterhouses were built which were then brought under strict supervision. Though initially unpopular, they were gradually adopted as business centers.

Food hygiene was given even more emphasis in the 1950s, as the number of restaurants and their customers increased, as more and more slaughterhouses were established, and as waste disposal became a problem. The supervision over food hygiene standards in the restaurants, teashops, and slaughterhouses were imposed not only on the main towns, but also on small villages as the resources of the department increased. Very small villages and settlements (on the coast and interior) were gazetted so as to facilitate supervision by the sanitary staff.¹⁶¹ By 1957, pit latrines were built, refuse collection organized, new

markets and slaughterhouses established, a permanent sanitary staff hired for each town, water pipes laid (in the main towns), and the food-hygiene standard of coffee houses and restaurants kept under watch. District commissioners cooperated with the medical staff in the improvement of coffee shops and eating-houses. For instance, owners of such businesses were persuaded to “alter them [buildings] to ensure adequate ventilation, to provide reasonable washing up facilities, and furniture, crockery and cutlery of a decent standard.”¹⁶² Those who refused to cooperate were put “under pressure” and threatened with refusal to “renew the license.” In cases where buildings were found to be below standard, they were either condemned or the license to operate was not renewed.¹⁶³ By 1958, all the main towns were reorganized into various types of residential, commercial, green zones, stock routes, and master maps produced that specified each zone.¹⁶⁴

The improvement in public hygiene was undertaken not only through administrative controls, but also through public education, which disseminated ideas and practices on the prevention of diseases, the improvement of infant welfare, sanitation, water supplies, and food hygiene in the homes, restaurants, and teashops. As one colonial report put it, the department regularly “arranges propaganda talks and health education to prevent diseases and raise the standard of general health of the people.”¹⁶⁵ Various institutions played a role in the public health education: radio Hargeysa, community centers, film shows, and “*War Somali Sidihi*,”—the main newspaper. Radio Hargeysa regularly held talks on such topics as the “Your Health,” and “How to Prevent T.B.” Ideas about disease prevention were also disseminated through booklets, such as the 1958, “Healthy Living,”¹⁶⁶ which was made available in bookshops, community centers, and was even used as a reader in adult education classes. Films, in addition, were used as a tool for the dissemination of public health standards. In 1958, for instance, the public health department produced with the cooperation of the Information Service, a short film on tuberculosis.¹⁶⁷ Other films on the prevention of diseases, which were produced elsewhere, were also used. When such films were shown, members of the Somali public health staff read a prepared script as a voice-over. In Some cases, they added commentary as apposite. The medical department and the Information Service also produced in cooperation other films on public hygiene, the dangers of venereal diseases, the

preservation of water, and other topics. Most were instructional films. In the community centres, moreover, regular film shows, and discussions and debates on public health were held. These centers were “very popular” and were patronised by the public.¹⁶⁸ In the hospitals and clinics the public health officers took full advantage over their contact with patients, and gave them “Instruction in simple hygienic principles.”¹⁶⁹

Meanwhile, the department undertook eradication campaigns characterised by “mass treatment”¹⁷⁰ against various diseases. As Megan Vaughn pointed out “mass treatment” of the population against some diseases was a common feature of most eradication campaigns in colonial Africa.¹⁷¹ A good example is the campaign against relapsing fever in 1949, 1950, and 1951. (Table 6 and Figure 1)

Table 6. Number of Dwellings Sprayed in 1949

Place Sprayed	Number of Dwellings	Amount of gammexane P.520 used, in cwt.
Burao	2,074	6.5
Hargeisa	7,020	13.0
Awareh	1,330	3.5
Odweina	397	2.0
Sheikh	428	2.5
Gabileh	416	2.5
Total	11,665	29.5

Source: W. C. D. Lovett, “Eradication of Tick-Borne Relapsing Fever in the Somaliland Protectorate By a Tick Destruction Programme,” *Transactions of the Royal Society of Tropical Medicine and Hygiene*, vol.50, no.2 (March 1956), p.163.

The spraying campaigns were systematic. They involved the entry into and search of all houses, cafes, mosques, shops, and restaurants in order to determine the number of ticks found in each place, and then to eradicate the ticks through spraying. Dust was removed from each premise, spread upon a well-lighted smooth surface, and then the ticks were counted. Satisfied that the agent of the disease was prevalent, every building was sprayed with gammexane P.520 in three consecutive months. The first and second spraying of Hargeysa lasted

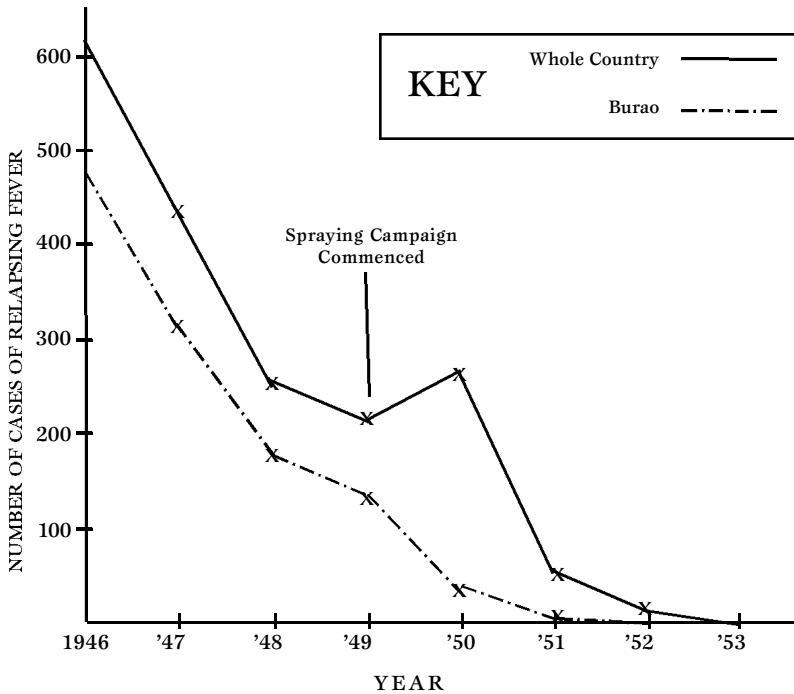


Figure 1. Incidence of Relapsing Fever 172

from 28 November to 21 December 1950 and from 22 January to 17 February 1951, respectively. Odweina was sprayed in March and May 1952. Burao was sprayed in December 1949 and in January and February 1950. The first and second spraying in Burao were large-scale operations. The permanent houses sector, the mud-brick houses and hut sector, were thoroughly sprayed. The final spraying was “carried out even though no ticks could be found in dwellings in searches done during the second campaign.”¹⁷³ The owners of shops, restaurants, and coffee houses were “loud in their praises and insisted that tick bites had ceased after the first spraying.”¹⁷⁴

The improvements in public health mitigated the impact of the diseases. But the successes of public health policies were always undermined by the steady and ever increasing migration from the rural areas to the towns. Neither the

public health department nor the central administration was happy with such migration. Colonial administrations throughout the continent were uncomfortable with the expansion of towns and cities, and with them, the infamous “detrified” African. Colonial administrators and public health officers were therefore committed to minimising migration from the rural areas—unless of course the labour of the African was needed in European economic enterprises. In Somaliland, both administrators and public health officers agreed that migration is the “greatest problem in the towns.”¹⁷⁵ The problem was addressed directly and indirectly: (a) directly through the control of prostitution, and (b) indirectly through the 1947 and 1949 ordinances, which prohibited vagrancy. In general, three approaches were taken by medical and administrative institutions within the framework of the ordinances. The first approach was to discourage young people from leaving the rural areas. The second was to deport young migrants back to the rural areas. The third was to control those who “cannot be retribalised” and “genuine orphans,” and train them to become “good citizens.”¹⁷⁶ The first two approaches were a complete failure. Nothing concrete was done to actually limit the migration of young people to the towns. The administration knew that poverty and the “hope of work” was the impulse behind migration.¹⁷⁷ The third approach was frustrated by the lack of resources. Besides, R. H. Smith stated, the problem of migration and the “beggar class ‘whether young or old,’ is present everywhere in the world, and is likely to increase until such time as the Somali becomes less dependent upon a purely pastoral livelihood.”¹⁷⁸

Dr. Leslie Housden, an officer to the Ministry of Health and an honorary medical officer for Save the Children, visited Somaliland in 1950 in order to investigate the condition of the “homeless boys.” He was less sanguine about the whole problem. He argued that the number of juveniles, juvenile crime, and the extent of poverty in the towns, are exaggerated. He found very few poor juveniles, and argued that the number of crimes juveniles committed were few. In 1950, he stated, there were “only 47 (juvenile) convicts in the main prison at the Mandera prison,” and of the 47 only 13 are in reality juveniles. He made three recommendations: (a) sending back juveniles to their homes in the rural areas, (b) finding work for those who had no family in the interior, and (c) establishing an approved school for abandoned children.¹⁷⁹ The first recommendation

was accepted but considered impractical. The second was rejected out of hand, because it would pose the “danger of making the towns an even more attractive lure than it is at present.”¹⁸⁰ The third was accepted, and in January 1951 funding was approved for building such a school that would teach juveniles “useful trades such as housebuilding, mat-weaving and food production on a small scale.”¹⁸¹ The school was officially opened in 1951 in Hargeysa. It was managed by the Save the Children, but supervised by the director of the department of public health. The curriculum of the school stressed practical education: carpentry, brick-laying, basket-weaving, tailoring, and gardening. The children were also given literacy lessons in English. The disciplining and training of the juveniles, however, was not restricted to the approved school. A juvenile wing was also opened at the Mandera Central Prison, where convicted juveniles and vagabonds were given special education in literacy and practical education. Two teachers were appointed to the prison to supervise their education as well as to instruct older prisoners.¹⁸² In 1955, however, the approved school was closed “on the grounds that the statistical figures did not reveal any real need for a separate institution.”¹⁸³ Juveniles were thereafter disciplined in the juvenile wing of the central prison, where they were “given two hours schooling daily and are required to work in the fields.”¹⁸⁴

Meanwhile, an attempt was made to control prostitution through the 1948 ordinance, which gave medical authorities the legal power to detain and segregate prostitutes.¹⁸⁵ But the enforcement of the ordinance ran into two difficult problems, particularly in Hargeysa, where the largest number of prostitutes resided. First, the public health department lacked the proper institutions to detain and rehabilitate prostitutes. The only disciplinary institution in the protectorate capable of performing such a task was the prison for women at Berbera, but it lacked the staff and the space to rehabilitate prostitutes. Second, prostitutes lived in the hut sections of the main towns, which were not planned, and where it was “difficult for the police to maintain law and order.”¹⁸⁶ Governor G. T. Fisher ordered in 1948 the removal and reorganization “in lines” of the hut section in Hargeysa¹⁸⁷ in order to extend proper policing and public health services, and to control and rehabilitate prostitutes. At first the police sought the cooperation of the residents of the area. As their cooperation was not forthcoming, the police decided to use force to remove the huts. The

police, however, “met with fierce opposition from women and children who stoned the Police while their men folk remained conveniently in the background.”¹⁸⁸ Some of the police were injured in the riot, and in order “to extricate themselves . . . fired into the air. One person was hurt but nobody was killed.”¹⁸⁹ The administration contemplated using more force to press the issue, but refrained due to a fear of yet another rioting. In the end, economic forces, rather than police force, pushed the hut section out from the center of the town. As the price of land rose in the 1940s and 1950s, there was a feverish land grabbing in Hargeysa, which pushed out the poor further and further away from the center of the town. The public health department directly controlled the new areas they set up their huts. By 1958, Hargeysa was completely reorganized “in lines,” even though the matter was not completely settled, since “unfortunately the drift to the towns continued and an ever expanding ring of hafas (hut section) formed suburbs to all the main towns.”¹⁹⁰

Public health programs were biased towards the towns, as this paper makes very clear, and as other scholars observed for the rest of colonial Africa.¹⁹¹ But the rural areas were not completely ignored. For instance, there were extensive malaria control programs in 1951, 1957, and 1958. During the 1951 malaria epidemic, the medical department treated water-wells and natural reservoirs, and distributed 1,754,000 tablets of quinine bi-sulphate.¹⁹² In 1957, moreover, the public health department treated 310 buildings and 2,763 mat-huts against malaria in the Haud.¹⁹³ The public health department also organized an extensive treatment campaign against malaria in 1958 in the Haud, where 310 buildings and 3,763 mat-huts were treated with D.D.T..¹⁹⁴ In the same year, the medical staff organized, with the help of three officers from the World Health Organisation, a survey of the breeding areas of the vector of malaria in the Haud, and the mountain range. Even though the people were reluctant to cooperate fully with the survey team and show them all their wells and watering places in the mountain escarpment, nonetheless the team was able to map the majority of anopheles breeding places in the mountain escarpment. In the Haud, the survey team met with no resistance, and so was able to map the anopheles breeding areas in the rainy season. The medical staff then regularly treated the water tanks and homes in the Haud against malaria up to the end of the colonial period, and also waged a campaign of public health education in the area.¹⁹⁵

There were other campaigns against, for instance, smallpox in 1943 and 1959 in the rural areas. The 1943 vaccination campaign against smallpox met with minor resistance. The Sultan of the Habr Awal (Isaaq) was suspicious of the campaign, and told the public that the vaccination campaign “was part of a design to make the population impotent.”¹⁹⁶ The Sultan was arrested and deported to Zeila. His intervention did not radically change the people’s attitude towards the campaign, because of the “confidence and desire for western medicine.”¹⁹⁷ Of course such “confidence” in western medicine was limited. The people of the mountain escarpment, for instance, were reluctant to show their watering areas and pastures to the 1958 survey team. In 1945 and 1951, moreover, riots erupted throughout the country in reaction to the treatment of the land with poison to control locust invasions. Nonetheless, the suspicions directed against western medicine were to some extent mitigated by the complex attitude of the people towards therapy. As Feierman and Janzen put it, the “history of therapy” in Africa “is a history of multiple healing traditions.” People attend to their sickness by consulting different traditions: colonial, Islamic, or traditional.¹⁹⁸ Even the traditional therapeutic system is differentiated.¹⁹⁹ The public health department, therefore, met with suspicion and resistance but to a limited degree. In 1959, for instance, the administration waged an active vaccination campaign against smallpox, yellow fever, cholera, and typhoid²⁰⁰ without any resistance. There were no epidemics of such diseases (except smallpox), but the department sought to prevent the incidence of the diseases, and so waged the vaccination campaigns. Such vaccinations were indeed an annual event throughout the country, as medical reports noted in the 1950s. The various vaccination campaigns as well as other medical programs that have already been discussed (control of prostitution, drug use, public hygiene, eradication campaigns against relapsing fever, malaria and tuberculosis, public education through the radio, posters, lectures, films, posters and plays, and formal curative institutions such as hospitals, clinics, and dispensaries) played an important role in controlling diseases in the towns and the rural areas. To a great extent, the relatively peaceful state of the country and the region also limited the introduction of new strains of epidemic diseases and so mitigated the impact of the diseases on public health.

Public health policies were not concerned only with the control of diseases. They also had a political dimension: the popularization of colonial rule, and the

administration of the population. As one of the most effective of the “superior magical powers”²⁰¹ of the colonizer, it played a role in the control of diseases and the improvement in public health as well as in the “consolidation of imperial hegemony.”²⁰² Science, and particularly colonial medicine, has always been “an instrument of state policy.”²⁰³ Colonial medicine always “occupied a central place in the ideological as well as the technological processes of colonial rule.”²⁰⁴ In colonial ideology, a well run hospital was considered as more powerful and effective way of winning the cooperation of colonized peoples than a battery of armaments.²⁰⁵ Administrators directly pointed to the political and social uses of colonial medicine. They considered it as the “first essentials to the progress”²⁰⁶ and popularization of colonial rule. Colonel F. R. W. Jameson, the Civil Chief of Staff of the East African Command, stated that colonial medicine must be given special priority because of its potential in “popularising the Government, and identifying the administration with the people’s welfare.”²⁰⁷ G. T. Fisher, the Governor of Somaliland from 1943 to 1948, went a step further and stated that “hygiene and public health are an important part of the administration of the country.”²⁰⁸ Public health policies, then, had both utilitarian and political objectives: to control diseases, to popularize the administration, and to discipline the population.

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